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ABSTRACT

The report discusses the prevention and treatment of child abuse and neglect in the Netherlands. Two Dutch institutions concerned specifically with the prevention of child abuse are described: a network of special teams consisting of doctors, social workers, and administrators; and the Society for the Prevention of Cruelty to Children. Aspects of these organizations considered include records, after care, reports and referrals, and statistics. Also discussed are cooperation between these two oganizations, public interest in family and youth welfare in the Netherlands, medical services related to child abuse, and legal aspects. Child guidance centers, agencies for general and family guidance, and social psychiatric services are among the mental health/social work services cited as pertaining to child abuse. Also described is an experimental hostel for problem families in Amsterdam, which serves as a live in sociotherapeutic center. Several obstacles that make it difficult to render effective assistance in cases involving child abuse cases are reviewed including lack of knowledge and resistance to reporting cases. (DLS)

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The Prevention of Ill-Treatment of Children in the Netherlands

There are two institutions in the Netherlands concerned specifically with the prevention of ill-treatment of children: the medical referees ("vertrouwensartsen") form one, and the other is the Society for the Prevention of Cruelty to Children ("Vereniging tegen Kindermishandeling").

I. Medical Referees concerned with the ill-treatment of children

In 1972 the government appointed four medical referees in different parts of the country, initially on an experimental basis. For various reasons, including their professional code of ethics, doctors were selected to fill these positions of trust. After a short time the medical referees started working in teams, each with a coordinating administrative officer and a social worker. The responsibility of the coordinating centres is threefold:

- a. Report and Referrals;
- b. Records;
- c. After-care.

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a. Reports and Referrals

There is no obligation in the Netherlands to report cases concerning the ill-treatment of children. However, anyone who is aware of or who suspects such behaviour may report the matter to a medical referee. The name of the person reporting the information is not passed on without his permission.

The medical referees and their social workers do not normally treat patients, except in very urgent cases. Sometimes the person reporting a case is able and willing to render assistance, with or without guidance from the coordinating centre. In other cases advice is given regarding the most suitable organisation to be consulted; occasionally the centre will call in other official bodies and sometimes it will deal with the matter itself. Preference is given to the assistance which is most naturally suited to a particular family, e.g. an

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institution or person already known to them. Contact is usually made with the family doctor. Service given by the medical referees is free of charge.

In 1975 and 1976, 33,8% and 38,2% respectively of the reports came from medical resources. The other cases were reported by educational, social welfare and child care authorities, by the police, the Society for the Prevention of Cruelty to Children, relatives, friends and neighbours. A small but growing number of parents have themselves sought assistance.

b. Records

The medical referees maintain records of all cases. These are listed by name, whilst certain particulars are filled in in accordance with a fixed system. The processing of this information is carried out nationally.

The purpose of registration is to acquire more insight into the nature, seriousness, frequency and background of cases. The information registered is treated in the strictest confidence. Information may be exchanged among medical referees, for example, when a patient moves to live in another area. The registration system is not entirely satisfactory and methods of improving it are being considered.

c. After-Care

It is the duty of the coordinating centre to check regularly on the progress and success of treatment, and, if necessary, to arrange for a change in treatment. A check must also be kept on other children in the family.

The medical referees (paediatricians or family doctors) work part-time. They must keep their experience of ordinary practice up to date as well. The other members of the coordinating centre are employed mostly on a fill-time basis and they must have had considerable experience in welfare work among young people. The coordinators are normally people with legal training (the team resembles the 'child-abuse team' recommended by prof. dr. C.H. Kempe). Appointments are made by the central government,

responsibility being shared by the Ministry of Public Health and Environmental Hygiene, the Ministry of Justice and the Ministry of Cultural Affairs, Recreation and Social Work. A multi-disciplinary committee (consisting in part of civil servants) supervises the work of the coordinating centres, gives advice and attempts to evaluate what has been done. As a result of their achievements, the medical referees as an institution are no longer regarded as experimental and consideration is now being given to organising them on a more permanent basis, although not full-time.

There are now 10 coordinating centres and it is hoped to increase this number. The number of reports has been shown to be stimulated by the proximity of a coordinating centre. The procedures of the coordinating centres are not fully uniform as each one must adapt itself to local conditions; the general framework of their operations is, however, the same everywhere.

Some statistical information

	1974	1975	1976
number of reports	823	815	896
boys	311	422	474
girls	512	393	422
age 0 - 6 years	51,2%	43,2%	46,2%
age 6 -12 years	30,7%	33,3%	32,3%
12 years and older	18,1%	23,5%	21,5%

Reports emanate from all strata of society. They are concerned principally with physical ill-treatment but a relatively large number refer to cases involving mental cruelty, and there is often a combination of the two forms. Whilst there is no doubt about the physical ill-treatment of children, there is still a good deal of discussion concerning the definition of mental cruelty. In practice the medical referees are guided by the information received from those reporting a case. Cases of ill-treatment up to the age of majority (21 years) have been reported.

In 1976 72,4% of the children could be left at home, provided there was proper attention for the child and the family. In 11,1% of the cases it was necessary to have recourse to a court order (in 1974: 8,4%; in 1975: 8,8%). Recent statistical information is not yet available.

II. The Society for the Prevention of Cruelty to Children

The Society was established in 1970 for the prevention of physical and mental ill-treatment and of neglect of defenceless children, owing to the increasing number of reports in the press about child abuse. The Society is organised privately and is open to all on a national basis. During the first few years its work was financed by private funds and by members; it is now subsidised by the central government, by members and by voluntary contributions. The Society has three full-time members of staff (a social psychologist, a sociologist, a librarian and 2 clerks) and 12 part-time workers, who work on a free-lance basis and give instruction throughout the country about child abuse and neglect to professional workers, students and the general public.

The Society originally served as a centre where reports were received. The procedure was largely the same as that now operating in the medical referees' coordinating centres. For the most part reports concerned cases when mental cruelty was the more important factor. The function of "reporting centre" was later taken over by the medical referee' coordinating centres. From its inception the Society took upon itself a second task which is now the more important: to provide information on the subject child abuse for the purpose of general and special prevention. The means adopted include the following:

- a. the transmission of knowledge of the battered child syndrome and of the work of the medical referees;
- b. the promotion of contact between specialists of different
- c. the stimulating of and participation in several projects.
- d. the encouragement of research.

a. With the transmission of knowledge the Society sets out to make the public familiar with cases involving the physical of mental ill-treatment of children, so that they may learn to recognise (and to describe in meaningful terms) the different manifestations of these cases. In the transmission of knowledge a distinction is made between the following:

a.1. the education of the general public e.g. parents and prospective parents, interested groups;

- directed towards responsible parenthood, the recognition of danger signals indicating ill-treatment or potential ill-treatment of children in one's own district, information about authorities which may be approached for assistance; by implication a change in attitude from punishment-orientated to assistance-orientated thinking.

a.2. instruction for (prospective) professional workers dealing with children;

- with the same objectives referred to under a.1. but in more depth, adapted to the particular professional group in question and any assistance rendered by the group.

a.3. a public awareness campaign about child abuse and neglect (1978/1979)

The four main objectives of this campaign were:

- to make people recognise child abuse and neglect
- to make people understand why certain parents abuse their child(ren)
- to encourage reporting
- to present the institutions, to which people can turn to for help

The means used to obtain the objectives were:

- free space advertisements in newspapers, magazines, professional journals
- free folders, brochures and posters
- a special t.v.-programme about child abuse and neglect of 50 min.
- 15 t.v.-spots of 30 sec.
- several articles about child abuse and neglect in newspapers, magazines, etc.

Some results of the campaign were:

- more requests for information
- more cases of child abuse have been reported
- the attitude towards child abuse has slightly changed.

Transmission of knowledge takes place:

- verbally by means of lectures, regular teaching or instruction and discussions with (working) groups;
- in writing by:
  1. the supply on request of appropriate information to those practising in the fields of medicine, social welfare and education, to students and other interested persons;
  2. the writing of articles for the press in general for specialist publications, family magazines, etc.;

  The publication of one of the first Dutch handbooks on the ill-treatment of children was brought about under the auspices of the Society (van Loghum Slaterus B.V., Deventer, 1974).

A section of the Society dealing with documentation also assists with the transmission of knowledge by searching for and collecting the many articles and books that have appeared throughout the world relating to child abuse. This section is open to all interested persons on a private as well as a professional basis. Some articles are being translated and/or edited. Every year a list of references which includes recent books and articles is being compiled from the documentations collected.

b. The Society organises regularly 'get-togethers' and symposia of one ore more days for professionals of various disciplines who are dealing with child abuse and neglect. Sometimes emphasis is placed on the exchange of information based on practical experience, on other occasions the meetings are mainly of a more instructive kind.

c. The past years the Society has stimulated and participated in severeal projects. Some of them are: - a project in a suburb of Amsterdam to recrute volunteers, who can be of help in child-abuse-families;
- a project to start a telephonservice for children. Children of all ages can call and ask for help or information. This telephonservice is working with trained volunteers.

d. Spring 1979 the Society has started a researchproject. Objective is to explore the different ways, the medical referees are working and how the medical referees cooperate with other institutions.

III. Cooperation between Medical Referees and the Society for the Prevention of Cruelty to Children.

The Society and the medical referees cooperate in the field of management, organisation and research. There is a regular exchange of information between the Society and the medical referees. The Society is concerned with the provision of information about the work of the medical referees and helping the referees to deepen and enlarge the scope of their activities.

IV. Family and Youth Welfare in the Netherlands - Public Interest.

When the Society and the Institution of Medical Referees came into being there was already a comprehensive network of family and youth welfare services in the country. It was never the intention, therefore, that the Society or the medical referees themselves should form a new organisation for giving direct assistance. Within the existing framework individual workers of various disciplines were, of course, already giving help in cases of child abuse; but they often had to work without the support of colleagues or of workers in other disciplines. For many institutions the ill-treatment of children was taboo and there was often clearly a lack

of knowledge of the subject. This was not surprising, for the 'battered child syndrome' had been recognised as such only a short time before. It is remarkable that those in charge of certain groups were at first somewhat reluctant to accept the information provided by the Society. They feared that it would be too much of a burden for those working in the field. Once these fears had been broken down the reaction of the field-workers often proved to be quite the reserve, and was one of relief. An attempt was made to present the problem in a frank and matter-of-fact way, and certain symptoms were referred to as being signs of a deeply disturbed family life adversely affecting both children and parents. Thus the ill-treatment of children was not in itself a phenomenon which is condemned but a symptom of a disturbed relationship. Whilst there was no ready-made prescription for tackling the problem, there was often a spontaneous and genuine willingness on the part of the workers concerned, to seek a solution and to try to direct more specific assistance towards the family. There is now considerable interest shown in these matters by professional and non-professional alike, and many people have a certain basic knowledge of the phenomenon, so that in courses the subject may be studied in greater depth.

In the prevention of child abuse it is usual to distinguish between different phases: prevention, detection (as early as possible), assistance and after-care. Various institutions operate in more than one phase, most in all phases, although with differing emphasis. Most of those rendering assistance try to keep the children within the family; sometimes, however, taking them away from home is inevitable and this can mean placement in a children's home, a foster home or a hostel.

V. Medical Services

The family doctor is a key figure in health care. He is the confidant of many families and sometimes attends them for more than a generation. He is often a social counsellor, too. There is a tendency towards group practices, to which people trained in other disciplines may be attached.

Health care in the Netherlands is comparable with the situation in most Western countries, i.e. with specialists who may or may not be employed in hospitals, policlinics, and, in larger places, special children's hospitals. Indeed there is one or more paediatrician on the staff of all hospitals, many of which also have social workers employed on an intramural or extramural basis. As health insurance is practically universal, the health services are readily accessible.

The so called "Cross" Organisation ("Kruis"verenigingen) occupy a special place in the health services. These bodies are active in every village and in the distrits of all larger places, whilst their membership amounts to approximately 82% of the population. The central figure of the Cross Organisation is the district nurse, who is fully qualified with supplementary (especially social welfare) training for this particular work. Many people in the district know "our" district nurse; she is universally respected and is a real support in times of trouble. Among those for whom she cares are people at home who are ill or who need attention. She also carries out duties of a preventive nature in many areas of health care. The district nurse often has the trust of "her" patients, enters easily into the family circle and can therefore fulfil a key role, especially in cases involving the ill-treatment of young children.

There are more than 2,400 Child Health Centres for babies and toddlers and these form an important element of "Cross" activity. The vast majority of children up to the age of 5 or 6 years are registered with the "Cross" centres which carry out regular checks on a child's general state of health and (physical and mental) development; they give inoculations as well as advice about nutrituon and upbringing. In the case of illness of abnormality they refer the patient to the doctor or elsewhere. The Child Health Centres are superintended by a doctor and a district nurse. Regular courses in child care and upbringing are arranged for mothers and fathers. Services are free of charge.

Many "Cross" Organisation arrange ante-natal care (including exercises) and maternity services. These services are very important as about 70% of all confinements in the Netherlands take place at home.

Finally there is often a home-help division which makes provision for domestic help to fill the place of the housewife. The home-help, or family welfare worker, can also have an educational influence. For maternity and home-help services payment is according to means.

VI. Mental Health - Social Work

A number of professional workers are active in this area in a variety of institutions, e.g. doctors (psychiatrists), nurses, social workers, psychologists and educationalists, with supplementary training and/or special interest in each other's disciplines; and finally non-professional volunteers (with some form of training). Attempts are being made to simplify the organisation which has become cumbersome over the years, and to improve cooperation.

The following are of special importance in respect of the ill-treatment of children: general social work, child guidance centres, agencies for general and family guidance and social psychiatric services. The latter are charged with the care of psychiatric out-patients as well as the preperatory treatment and after-care of in-patients.

Extensions of this field of activity are to be found in the following:
- (medical) day nurseries and residential nurseries and pre-school play-groups (with the assistance of social workers);
- district centres with various types of educational and semi-social work;
- schools - school medical services (medical and social); school counselling services (psychological, didactic and social); school welfare services; schools for groups of children with special handicaps, and with learning and behavioural difficulties; these are nearly always primary schools;
- compulsory educational courses with a strong social bias for working boys and girls of 15 and 16 years of age;
- various associations for mutual assistance, often supervised by social workers (or social work agencies).

VII. "De Triangel" Socio-therapeutic Centre at Amsterdam

This centre was established in 1972 as an experimental "hostel" for problem families. Cases involving the ill-treatment of children had occurred in a number of the families admitted to the Centre. (This sort of behaviour is not considered as a phenomenon in itself, but as a crisis point in a disturbed family life).

As there is a great deal of interest in "De Triangel" and as good results have been achieved there, the following information is being made available. It may be of interest to note in passing that there are plans that similar institutions will be established in other parts of the Netherlands

Circumstances leading to admission include the following

- the family problems are such that one or more of the children are at risk;
- difficulties originate principally within the family itself and are not caused by external circumstances. If the latter are very difficult, this is a 'negative indication' making admission inadvisable;
- the expectation that a short stay (4-6, or 8 months at the most) will have a highly favourable influence on further treatment at home;
- the family is able to accept the assistance envisaged.

A distinction is made between the following phases, which are not strictly separate:

1) Permitting the family to settle down in a friendly, informal atmosphere, without discussions.
2) Gradual realisation on the part of the parents and older children of the possibilities of changing their behaviour and the reaction to this younger children.
3) Dealing with the clients' desire to return to their own home and with the necessary arrangements.

As far as possible therapy is geared directly to the clients' behaviour. Conflicts are discussed immediately. This work demands a tremendous effort by qualified teamworkers who must be prepared to do any kind of job, such as helping to wash dishes or wash and change children. It is not claimed that the work is carried out in accordance with a system

based on scientific principles (it is a matter of making oneself available, of being present when required, rather than placing a label on people). It is not so much having an abstract objective - the strenghtening of the ego, for example; it is more a case of the restoration of a normal and enjoyable family life, for example restoring their pleasure in cooking tasty dishes, in caring properly for their clothes and hair, etc., in brief, in living together in a cheerful, sociable manner; it is a case of appealing to the positive side of the client and helping him to develop in the direction of his choice. In this sense the "Triangel" would like to be regarded as a model for other institutions which operate in a more formal manner. A short-stay centre which is comparable with the "Triangel" is being established for the after-care of families treated at an earlier stage in the "Triangel".

Because of the importance attaching to the client's way of life the "Triangel" is unable to receive any visitors, including foreign visitors.

VIII. The Law

The ill-treatment of childrens is an offence in this country. Convictions, however, are rare, being less than 10 a year. On the one hand this may be because of the difficulties of providing proof; on the other it is undoubtedly a question of attitude - a shift from punishment-orientated to assistance-orientated thinking.

In cases of physical and mental ill-treatment and neglect certain measures may be taken in accordance with well-defined provisions in civil law for the protection of minors (the age limit is at present 21 but will probably be reduced to 18 years shortly). These measures are possible only if they are in the interest of the child. Orders of a light nature are made by a Juvenile Magistrate sitting alone; those of more serious kind are made by a Court (consisting of a Bench of three Magistrates one of whom must always be a Juvenile Magistrate). Before making an order the Court must receive advice from the Child Care and Protection Board, of which there is one attached to each Court. The Board comprises a group of qualified private citizens, appointed by the central government, with executive assistance from professional civil servants, jurists and social workers.

Legal measures available

1. Placing under supervision - with the permission of the parents or guardians. This order limits parental authority, in principle for not longer than one year at a time. The parents receive assistance in raising the child from a 'family supervisor', who is either professionally trained or a volunteer. As a rule the child remains at home but it is also possible to arrange for boarding out on a temporary basis.
2. Relief of parental authority or legal guardianship - as a rule with the permission of the parents or guardians; on more serious grounds.
3. Deprivation of parental authority of legal guardianship - is possible against the wishes of the parents or guardians; on very serious grounds.

Under orders 2 and 3 above it is usual for a private organisation to be charged with the guardianship. The child is placed away from home in a foster home of in a public or private children's home of which there are many different kinds. Orders 2 and 3 may be revoked and restoration of parental authority is possible.

4. If the interests of the child make it necessary it may be "committed temporarily", under very strict rules, to the care of the Child Care and Protection Board. The Board then arranges for a place of safety for the child. In cases where the parents are opposed to treatment which is regarded as medically necessary, the place of safety is often a hospital. This is always a temporary measure. The Court must take appropriate action quickly (see above) or terminate the committal order if it is no longer necessary.
5. Adoption - the adoptive parents replace the parents fully and permanently. Adoption orders are not often made in cases of ill-treatment of children.

Opinion is virtually unanimous that a break in parental authority can have far-reaching consequences and is therefore justifiable only if it has been found impossible to assist the family on a voluntary basis and if the child is too much at risk. As stated earlier medical referees have had recourse to legal assistance in less than 10% of the cases.

IX. Possible Measures to overcome Difficulties

There are a number of obstacles which make it difficult to render really effective assistance in cases involving the ill-treatment of children.

The principal ones are:

- Lack of knowledge and resistance to reporting a case. In spite of all the publicity and information, many workers still have insufficient knowledge concerning the ill-treatment of children. Many cases are not even recognised as involving child abuse and there is still little known about the background to and the incidence of this type of offence in the Netherlands.

  Slowly but surely the situation is improving. One of the purposes of the registration of cases and the maintenance of records by medical referees is to fill this gap in knowledge. [illegible] resistance in various forms of child abuse. The Society for the Prevention of Cruelty to children is trying to encourage open discussion, and a film about child abuse has been produced under its auspices.

- Work is being carried out in various areas on effective preventive measures. Whilst there is as yet no cohesive policy a step towards improvement will be the planned extension of the number of medical referees to eleven. Because interdisciplinary cooperation is necessary in cases involving the ill-treatment of children, more attention is now being paid to this in training and refresher courses.

The above provides a brief description of the position in the Netherlands regarding the prevention of the ill-treatment of children, and the possibilities available for assistance. We should be pleased, of course, to provide you with additional information either verbally or in writing. We should be very grateful to receive any comments and suggestions you may wish to make.

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The Haque, august 1979